PSYCHOLOGY CASE RECORD

Submitted to the Tamil Nadu Dr. M.G.R. Medical University in partial fulfilment of the requirements for the Diploma in Psychological Medicine Examination 2016

By
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I would like to thank my parents, family and colleagues for their support.

I would like to express my sincere thanks to all the patients and their families who kindly co-operated with me even though they themselves were suffering.

CERTIFICATE

This is to certify that this Psychological Case Record is a bonafide record of work done by **Dr. Debanjan Mandal** during the years 2014-2016. I also certify that this record is an independent work done by the candidate under my supervision.

Dr, Anju Kuruvilla,
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Mrs. Sushila Russell, M.Phil,
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CASE RECORD - 1 : Personality Assessment

Name	: Mr NT
Age	: 20 years
Sex	: Male
Marital status	: Unmarried
Religion	: Christian
Language	: Malayalam, English
Education	: B Sc Physics 2nd year
Occupation	: Student
Socio-economic status	: Middle
Residence	: Urban
Informant	: Mr. NT. and his parents

Presenting complaints

Preference for solitary activities	- since childhood
Odd behaviours	- since childhood
Declining academic performance	- 6 year

History of presenting illness

Since childhood, Mr.NT reportedly had reduced attention span & restlessness when compared to his peers. He had very few friends, and he preferred solitary activities rather than interacting with his peers. He preferred not to mingle with his peers as his thinking and behaviour were peculiar when compared to his peer groups' usual socio-cultural norms. Academically, he was apparently doing well till six years back, when he failed in 9thgrade exam. He was put in a state board school where he did well in 10th std., but again was put in a CBSE board school in 11thgrade against his will. He had difficulty in coping with the curriculum of his new school. He was suspended from this school within six months of joining, school authorities citing his restlessness as a reason and also a feedback he gave to the authorities about the school where he compared that school with a jail. He was put in a new school in 12thgrade but did not show interest in studies. Gradually he started expressing a desire to join the film industry and become a film director, against his parents' wishes. Most of his thinking and actions have been directed towards that. He felt that his parents were not taking him seriously, and not giving him space. He joined B. Sc. course in physics, but was not interested in academic career. He preferred to be involved in his own fantasies, associated with circumstantial and metaphorical thinking. Over the past one year there is history of exacerbation of his allegedly poor attention and concentration. The above mentioned impaired attention was not evident while following any activity which was in line with his interests.

There is no history of any psychoactive substance use in an abuse or dependence pattern.

There is no history of any organicity around the time of onset of his symptoms.

There is no history of any ideas or attempts of deliberate self harm.

There is no history of any delusions or first rank symptoms in the past.

There is no history of any manic or hypo manic symptoms in the past.

There is no history of any obsessive-compulsive symptoms in the past.

There is no history of any other specific personality traits.

There is no history of any primary sleep or sexual dysfunction in the past.

Treatment history

He has been treated with multiple psychotropic medications (dosage not specified) for varying diagnoses in the past 6 year with minimal improvement in his symptoms. His most recent prescription revealed Bupropion, Lithiumand Olanzapine, with which there has been no improvement.

Family history:

There is no family history of any neuropsychiatric morbidity. He is the only child born out of a non-consanguineous union of his parents. His mother is a housewife, father is a manager in a hotel. He was staying in a joint family set up till the past three years and currently stays in a nuclear family set up. He is very close to his mother, grandmother & a cousin sister. There was no significant marital discord between his parents.

Birth &Developmental history

The antenatal period was supervised and uneventful. Delivery was full term normal vaginal with no birth asphyxia or neonatal seizure. Postnatal period was uneventful. His developmental milestones were reported to be normal.

Educational history:

He is currently pursuing his Bacherlor's degree in Physics and is in his second year of the course. He is reported to be an average student in academics. There were reports of inattention and restlessness when he was at school.

Sexual development

He has male gender identity and heterosexual orientation. He denied having any masturbatory guilt. He denied any high risk sexual behaviour.

Marital history

He is unmarried

Premorbid personality

Premorbidly he is being described as a shy, anxious and introverted person. He had difficulty in socialisation, with reports of very few close friends. There were no other specific personality traits as reported by his parents.

Physical examination

His vitals were stable. Systemic examinations were within normal limits.

Mental status examination

Mr NT was a thinly built individual, with a completely shaved head and was appropriately kempt. He maintained eye contact and rapport was easy to establish. During the initial interviews he was fidgety with expressions of odd facial mannerisms during communication. He appeared distressed and restless, shuffling his position in the chair repeatedly. There were oddities in his behaviour such as a request for the fan be switched off even though he was found to be sweating profusely. He was able to follow complex commands. His reactive movements were exaggerated. His speech was spontaneous, with adequate comprehension, loud, rapid and relevant to the question asked. He would however frequently request verbal communications to be repeated, since he was unable to comprehend parts of the conversation. He appeared anxious with stable & appropriate affect. His subjective mood was euthymic. He denied suicidal ideations. There were no abnormalities in his form. His stream of thought revealed circumstantiality. His content of thought revealed concerns about future and conflicts with parents. He denied delusions or depressive ideations. He was found to mutter to self but denied the presence of any hallucinations. He was oriented to time, place and person. His attention was could be aroused but was difficult to sustain. His memory functions were intact. His intelligence was average. His personal and social judgments were deemed mildly impaired while his test judgment was intact. He had partial insight into his illness.

Provisional diagnoses

- Schizotypal personality Disorder
- Undifferentiated Schizophrenia continuous course

Aim for psychometry

To identify and explore significant personality factors influencing the psychopathology

Tests administered

1. Sack's Sentence Completion Test
2. The International Personality Disorder Examination Questionnaire (IPDE) - ICD 10 Module
3. The 16PF Personality Assessment Tool
4. Rorschach's inkblot test

Behavioural observation

He was cooperative for the assessment. He was able to comprehend the instructions given to him and was able to communicate appropriately. There was no performance anxiety observed. There were oddities observed in his behaviour such as inappropriate smiling or laughter. There was extensive description of some responses.

Rationale for the test

Sacks Sentence Completion Test is a projective test developed by Dr Sacks and Dr Levy. It consists of 60 partially completed sentence to which respondent adds endings. The respondent projects the attitudes towards a personal experience of life. It helps to elicit ideas of self-perception.

Test findings

It indicates conflicts in the area of family and self and sex. There appears to be some conflicts in his attitude towards his parents. He is closer to his mother than father. While he seems to consider them very good, he feels that his father is overcritical of him and is displeased by it. There appears to be fear of failure & low self-esteem. There is masturbatory guilt & regret about his illness. There seems to be no major conflicts in interpersonal relationship. The test also reveals that he has conflicts in the area of sexual relationship as he remains guarded about it.

Rationale for the test

IPDE (WHO)-The IPDE developed by Dr.Armand.B.Loranger and colleagues is a semi-structured clinical interview that provides a means of arriving at the diagnosis of major categories of personality disorders and of assessing personality traits in a standardized and reliable way. This was chosen to screen for prominent ICD 10 personality traits.

Test Findings

In the IPDE, his answers suggested of high loading of anankastic, histrionic and borderline traits.

Rationale for the test

16PF Test is developed by Raymond Cattell measures the 16 primary personality traits and the big five secondary personality traits. This was considered to explore for prominent personality traits.

Test Findings

The 16 PF reveals that he tends to be liberal in his thinking -- even beyond the logical boundaries. He tends to be open minded and has a tendency to challenge socially accepted views which may cause friction with others and may come across as "abnormal". He has a tendency to not be receptive to subordination. He tends to be careless, disorganized, casual and disciplined but flexible. He tends to be less goal oriented and unconcerned about details. He tends to be impatient, highly strung and fidgety.

Rorschach Ink Blot Test - It is a projective test which provides an understanding of structure of the personality, probable psychosis if any, affectional needs and the ego strength. It also indicates degree of psychopathology

Test findings

In the Rorschach protocol, he has given 23 responses indicating average productivity and mentation. The protocol indicates a tendency for immediate gratification of needs range than long range goals. His inner tensions result in difficulty in handing everyday problems or issues. There is an underdevelopment of the need for affection. Insensitivity to shading reveals basic defect in her personality organization resulting in poor adjustment to life. He tends to be

restrained in his interactions with others and will find it difficult to make warm and close affectional contacts. Forced colour responses also indicate a tendency to have tension in social relationships and difficulty in maintaining smooth interpersonal relationships. There is a lack of responsiveness to environmental influence. His inner tensions tend to interfere with his ability to sense essential relationships between various facts of his experience. There is an overemphasis of W cut responses indicative of an over critical and perfectionistic approach which tends to inhibit the processes of generalization and integration. Under emphasis of d responses reiterate his tendency to lack recognition of everyday problems and facts. He tends to have an overcritical attitude towards self that may result in anxiety. High animal percentage indicates a stereotyped attitude towards life. There are low numbers of popular responses indicating weak ties with reality. Content analysis indicates variety in content suggestive of intellectual efficiency.

Conclusion

The tests administered were suggestive of an individual who was impulsive and disorganized but also obsessive in nature. This conflicting inner tension between impulsivity and control may account for the oddities in his behavior. Projective tests reveal good intellectual ability with poor ties with reality and difficulty in interpersonal relationships. There appears to be a discrepancy between results of tests which may be explained by a tendency to provide socially desirable responses.

Management

Mr. NT was admitted voluntarily as an in-patient for the purpose of diagnostic clarification and subsequent rationalization of medications. Consequent to rationalization of medication was done. With gradual escalation of doses and non pharmacological interventions, he was observed to have an overall improvement in his anxiety and agitation. He was observed to be composed during sessions as well as interaction with other members. After discussing with him and his family members, a common set of targets were identified, which included personal care, family responsibilities, socialization and academic performance. With the help of a time schedule with regular rewarding he was found to have improvement of his personal care as well as taking up simple responsibilities. Individual sessions were held discussing appropriate communication skills as well as measures to reduce anxiety and stress by practicing breathing exercises and mediation skills. The need for maintaining a structured environment was repeatedly reinforced in sessions. He was also encouraged to attend the occupational therapy (OT) where the above mentioned goals were targeted. He was found to be fairly regular in his OT attendance and performance in group activities. Study techniques were also discussed with in individual sessions.

The parents were psycho-educated regarding his illness nature course and prognosis. They were distressed by understanding the same. They were duly supported during the process in repeated sessions. The need to continue the behavioral techniques with rewarding was also reinforced. Post discharge plans of resuming his academic course was made after discussions.

CASE RECORD – 2 : Intelligence Assessment

Name : Mr. S

Age : 21years

Sex : Male

Marital status : Unmarried

Religion : Hindu

Language : Bengali, English

Education : B.A. 1st year

Occupation : Student

Socio-economic status : Middle

Residence : Semi urban

Informant : Mr. S.M. and his parents

Reliability : Good

Presenting Complaints

- Poor academic performance
- Demanding behaviour

- Anger outbursts
- Inappropriate behaviour towards women

History of Presenting Complaints

Since childhood, Mr. S's academic performance was below average but there had been no failures in any class till he completed his school. However, despite completion of 12th grade, his fund of knowledge was below what was expected.

He presented with behavioural problems such as demanding behaviour & temper tantrums. He would demand to go out almost daily to meet relatives, would get upset if this demand was not met and express through anger outbursts and shouting behaviour. He would use foul words in the presence of his parents. These problem behaviours were mostly present at home. There is also history of inappropriate behaviour towards females such as staring at them, smiling inappropriately to them, gesturing, making odd noises intended towards them. However, there has been no history of any physical inappropriate behaviour towards them. He was independent in self care, but often needed prompts. His behaviour was reported to be age-appropriate by his parents. His socialization was limited but he was able to engage in conversation for short periods. He was able to perform simple calculations but had difficulty with complex calculations. He was able to do minor purchases from shops.

There was no evidence to suggest any psychotic symptoms or mood symptoms at the time of his assessment.

There is no history of any psychoactive substance use in an abuse or dependence pattern.

There is no history of any psychotic symptoms in the past.

There is no history of any pervasive mood symptoms in the past.

There is no history of any anxiety spectrum symptoms in the past.

There is no history of any specific personality traits in the past.

Past & Treatment History

He had been treated with multiple antipsychotic medications and mood stabilisers from various private psychiatric centres prior to his visit to the outpatient clinic. He is a known case of Hypothyroidism for the past one year and is on Thyroxine supplement.

Family History

There is no family history of neuropsychiatric morbidity. There is no history of mental retardation in his family. His father is a serviceman and his mother is a housewife. He does not have any siblings.

Birth and Development History

His birth was from a planned pregnancy with supervised antenatal period. He was born pre term and of caesarean section at hospital. His birth weight was 1.72kg.He had delayed birth cry and there is history suggestive of birth asphyxia. He was kept in an incubator for one week after

birth. There were no other complications like jaundice or seizure. He was adequately immunized for age. There was global delay in development. He started walking at the age of two years and speaking at the age of one and half years.

Emotional Development and Temperament

He was described to be an introverted, shy child with restricted social interaction. He liked to play computer games. There were no features suggestive of attention deficit/hyperactive disorder or oppositional defiant disorder.

School History

He had completed his 12^{th} grade and had gained admission for a Bachelor's degree. However, he could not continue his studies as he found it difficult. His academic performance was below average in school and he failed once in 10^{th} grade. His medium of instruction was Bengali and he found English difficult.

Occupational History

He was a student and had not held a job so far.

Sexual History

He admitted doing occasional masturbation. He denied having any masturbatory guilt. His libido was normal. He denied any dysfunction or risk behaviour.

Physical Examination

His vital signs were stable. There was congenital absence of left thumb. Mild divergent squint was noted. Systemic examination was within normal limits.

Mental Status Examination

He was well built, nourished and was appropriately kempt. Rapport could be established. There were no abnormal motor movements. His speech was spontaneous, loud with decreased reaction time and occasionally irrelevant. His mood was euthymic with normal range and reactivity. He denied delusions, hallucinations and obsessions. He was oriented to time, place and person. His memory was intact. His attention could be aroused but was difficult to sustain. Intelligence was below average. Insight was partial and judgment was impaired

Provisional Diagnosis

Borderline to mild intellectual disability, with behavioural problems

Aims Of Psychological Testing

As history was suggestive of global developmental delay, poor academic performance, below average performance in socio-occupational functioning and mental status examination revealed impairment in tests of abstraction, arithmetic and general knowledge, IQ assessment was imperative.

Test Administered

Binet-Kamat Test of General Mental Abilities

Rationale for the Test

Binet-Kamat Test (BKT) was used to assess intelligence as it is a standardised I.Q test for the Indian population

Behavioural Observations

Mr. S.M.was cooperative for testing and was able to comprehend the simple instructions but had difficulty in comprehension of more complex instructions. He appeared quite anxious and had be reassured periodically. He was able to sustain his attention over the course of the assessment and was able to communicate adequately. His eye contact was poor however.

Test Findings

On BKT, the basal age attained was 8 years, terminal age was 14 years and the mental age was 10 years and 6 months with the corresponding IQ being 66, indicating mild mental retardation. However, scatter is seen in the assessment – his performance is poor in items measuring abstract ability such as conceptual thinking or verbal or numerical reasoning. However, on items that involve rote learning, his performance is better. His social intelligence and language function was average.

Impression

Although the IQ is found to be in the mild mental retardation category, his language ability and social intelligence appears to be much higher suggesting his IQ to be in the borderline category. The low IQ may be due to his poor performance in items measuring abstract ability.

Management

Rationalisation of medication was done. Antipsychotic & mood-stabiliser medications were gradually tapered & stopped. Thyroxine was increased to 75mcg/day after Thyroid function tests.

Behavioural techniques such as activity scheduling for a structured routine and differential reinforcement for his behavioural problems were employed.

Parents were psychoeducated about the nature & course of his problems. They were allowed to ventilate & support was provided. Vocational plans were discussed.

CASE RECORD – 3 : Diagnostic Clarification

Name	: Mr. PS
Age	: 29 years
Sex	: Male
Marital status	: Separated
Religion	: Hindu
Language	: Bengali, Hindi
Education	: Graduate
Occupation	: Unemployed
Socio-economic status	: Middle
Residence	: Semi urban
Informant	: Mr PS and his parents

Presenting Complaints

- Inability to control anger and impulsive behaviour
- Abusive behaviour towards parents
- Disregard for usual social norms
- Suspiciousness that people are not to be trusted at all

- Belief in supernatural powers & Pseudo-philosophical ideas
- Recurrent sexual thoughts
- Hearing non-existent voices
- Attempts of deliberate self-harm
- Excessive smoking
- Poor socio-occupational functioning including separation from wife

History of Presenting Illness

Mr. PS was apparently functioning well in his childhood. There is probable history of frequent physical abuse for disobedience during his childhood & adolescence by family members including his mother, resulting in a strong attachment towards peers. He started smoking cigarettes, skipping classes under their influence. He gradually began to express disregard to usual family& social norms such as insulting elderly people including teachers and parents. This resulted in a gradual decline in his academic performance. He became irritable easily when things were not going his way and was unable to control his anger. He began to abuse his parents both verbally & physically. He gradually lost interest completely in academics and in securing a vocation and became more interested in theosophical, spiritual &pseudo-philosophical matters, and started to spend most of his time on this. He began to read books written on these topics and practice these ways. He began to express a staunch belief in this and developed a distrust towards human beings as he considered them unfaithful. He became suspicious towards people including parents and other family members. He began to develop and hold grudges for years against people who had earlier hurt him emotionally or physically, however minor it was, and never

forgave them. This was manifested by avoiding social interaction and plans on seeking vengeance but has never harmed anyone else physically apart from his family members.

He reported hearing voices of goddesses he worshipped, mostly before going to sleep. He denied hearing voices when awake. Parents didn't notice any hallucinatory behaviour.

He expressed severe dislike and hatred towards women. He gave reasons citing incidents from his life where he was hurt by females, starting right from his childhood till recently when his wife left him within a week of marriage.

There is history of chronic smoking for the past fifteen years in dependence pattern and he currently smokes between twenty to thirty cigarettes per day. There is history of occasional alcohol consumption, but no evidence of dependence. There is no history of any other psychoactive substance use in a harmful use or dependence pattern in the past.

There is history of deliberate self harm one month back when he consumed multiple unknown tablets following a fight with parents. The attempt was impulsive in nature, of low intentionality & lethality. There was no history of any complications.

There is no history of seizure, head injury, or any other organicity.

There is no history of any first rank symptoms.

There is no history of any pervasive mood syndrome.

There is no history of any generalized anxiety or panic attacks.

Treatment History

He has been treated for these problems by several psychiatrists since last fourteen years. However, the proper details regarding the medications were not available. He received treatment with Risperidone (4mg/day), Valproate (1000mg/day), Clozapine (300mg/day), Amitriptyline (25mg/day), Fluoxetine(60mg/day) in the past. At the time of his index visit tothe OPDhe was on Paroxetine (25mg/day), Mirtazapine (15mg/day) andClonazepam (2.5mg/day). Inpatient stay was planned for diagnostic clarification & rationalization of medication.

Family History

He is the second & lastchild born to his parents from a non-consanguineous union. There is no family history of any neuropsychiatric illness. His father is a retired serviceman and his mother is a homemaker. His elder sister is a homemaker.

Birth and Developmental History

The antenatal period was supervised and uneventful. Birth was full term normal vaginal delivery with no birth asphyxia or perinatal complications. Postnatal period was uneventful. Both motor and language developmental milestones were reported to be normal.

Educational History

He has completed a bachelor's degree in arts. His academic performance was reported to be average. He had good interaction with his peers and teachers until the onset of his symptoms.

Sexual History

He has male gender identity and heterosexual orientation. He admitted to masturbation without anyassociated guilt. He denied any high risk sexual behaviour.He also reported having recurrent sexual thoughts towards elderly women, which was not intrusive or ego-dystonic.

Marital History

He was married to Ms CN, a 27 year old lady, till two months back. He was separated from his wife within a week of marriage. He reported that he was not happy with his wife.

Premorbid Personality

Premorbidly he is described to be astubborn person who was overly sensitive to criticism. He was not sociable. He had easy irritability, poor frustration tolerance & poor control of anger. He lacked energy, initiative & responsibility towards work. He did not have good moral standards. He did not have regard for family or social norms.

Physical Examination

His vitals were stable and systemic examination was within normal limits.

Mental Status Examination

He was moderately built and adequately kempt and maintained good eye contact. Rapport was partial initially. However, with serial interviews, rapport was established gradually. He had rapidly changing expression and fidgety during the interview. His speech was spontaneous, relevant, garrulous in productivity, with rapid reaction time and speed. There was mild overfamiliarity in his speech. His mood was irritable with normal range but increased reactivity.

He denied any active suicidal ideations. His thought process revealed circumstantiality. His content of thought revealed suspicious beliefs towards family, ex-wife, but no clear delusion was evident. He expressed hypnogogic auditory hallucinations. He was oriented to time, place & person. His memory functions were intact. His attention could be aroused but was difficult to sustain. His intelligence was average. His personal and social judgement was impaired. He had partial insight to his problems.

Provisional Diagnosis

MIXED PERSONALITY DISORDER -- dissocial, paranoid & emotionally unstable traits

SCHIZOPHRENIA

Aim for Psychometry

To clarify symptomatology, psychopathology and diagnosis

Tests Administered

1. Sack's Sentence Completion Test

2. Thematic Apperception Test

3. Rorschach Inkblot Test

Behavioural Observation

He was cooperative to do the assessment. He was able to sustain his attention over the course of the assessment. There was no performance anxiety observed. He was able to communicate without any difficulty. Odd behaviours were seen such as holding the test materials at acute angles and keeping it extremely close to his eyes and gesturing with his fingers.

Sacks Sentence Completion Test

Rationale

Sacks Sentence Completion Test is a projective test developed by Dr.Sacks and Dr.Levy. It consists of 60 partially completed sentences to which the respondent adds endings. The respondent projects the attitudes towards a personal experience of life. It helps to elicit ideas of self perception.

Test Findings

It indicates conflicts in the areas of attitudes towards family, self and sex. There appears to be severe conflicts in his attitude towards his parents. He feels that his parents, especially father, is overcritical of him, treats him like a child and is very displeased by it. There appears to be fear of failure & low self-esteem. There appears to be significant amount of guilt regarding his interpersonal problems with his parents and regret about his relationships with the opposite gender. The test also reveals that he might have been abused physically in childhood. There seems to be histrionic & paranoid traits in him. The test also reveals that he has significant conflicts in the area of sexual relationship as he expressed both disliking & desire about women

Thematic Apperception Test

Rationale

Thematic Apperception Test is a projective test used to measure the person's pattern of thought, attitudes, observational capacity and emotional responses to ambiguous test materials. It elicits information about a person's view of the world and his attitudes towards the self and others.

Test Findings

In the TAT, the stories are very detailed and long. All the stories are in the third person and he does not identify himself with the hero in any of his stories. The dominant themes of the stories are need for achievement, aggression, playmirth, dominance and sentience. The stories also reveals feelings of inferiority and anger, rage. Conflicts between being aggressive versus abasement and aggression versus mirth are seen. There press in the environment in the form of ridicule, dominance from superiors and aggression. Sublimation, displacement and projection are the dominant defense mechanisms observed.

Rorschach Ink Blot Test

Rationale

Rorschach Ink Blot Test is also a projective test which provides an understanding of structure of the personality, probable psychosis if any, affectional needs and the ego strength. It also indicates degree of psychopathology.

Test Findings

On the protocol he has given 21 responses indicative of average productivity with delayed mentation. The need for affection appears to be poorly developed indicating significant lack of emotional depth which could cause problems or difficulties in adjustment to situations in life. Insensitivity to shading further indicates his poor development of need for affection. It indicates a tendency to act out his emotions due to the lack of need for approval or affection from others and therefore is not held back by societal norms. His tends to have poor control over his emotions. The protocol indicates an individual with high intellectual capacity and creativity, who tends to delve in to escapist fantasy as a substitute for actual achievement. Overemphasis of form indicates an inability to perceive his own needs and the nuances of his emotions. He also tends to be disturbed by emotional impact from the environment. High animal percentage indicates a stereotyped view of the world and difficulties in adjustment. The presence of eye responses indicate paranoid traits. Disregard for colour is seen indicating poor efficiency in dealing with social situations. The low number of human responses indicates her tendency to establish a wall between herself and others and isolate herself. Sex responses and impulsivity indicate the presence of significant conflicts in his attitude towards sex. High numbers of anatomical responses indicate a preoccupation with his body and sadistic tendencies.

Conclusion

The test findings revealed histrionic and impulsive traits in an individual with poor control over his emotions, negative attitudes towards others, especially women, lack of remorse for his actions, and a tendency to bear grudges. These were suggestive of a diagnosis of mixed personality disorder with prominent dissocial, paranoid and histrionic traits. The findings did not reveal the presence of any psychosis or mood syndrome.

Management

He was admitted for diagnostic clarification and appropriate treatment. As there were no psychotic or mood symptoms, his psychotropic drugs were gradually tapered and stopped. The treatment was planned based on non-pharmacological principles. The parents and sister was allowed to ventilate and the nature of his problem was explained. With the patient, his perspective of the problem was taken and understood without being judgemental. An activity schedule was given for his day to day routine work. Techniques such as anger management, assertiveness training was discussed and demonstrated. Stress reduction technique like JPMRT, Deep breathing exercise was demonstrated. His dysfunctional assumptions and pseudo-philosophical ideas were challenged with cognitive and behavioural principles.

CASE RECORD – 4 : Diagnostic Clarification

Name	: Mr. AD
Age	: 21 years
Sex	: Male
Marital status	: Unmarried
Religion	: Hindu
Language	: Bengali, English
Education	: BA 1st year
Occupation	: Unemployed
Socio-economic status	: Middle
Residence	: Semi urban
Informant	: Mr AD and his parents

Presenting complaints

- Repetitive thoughts about and a need to feel right about everything before performing specific acts
- Need to hold on to objects for a long time before releasing it
- Irrelevant talk

- Abnormal voluntary posturing of limbs
- Poor self-care
- Decreased food intake / refusal to eat
- Decline in socio occupational functioning and academic performance

History of presenting illness

Mr AD was apparently functioning well until about seven years ago when he began to express to family about having to take control of his life leading to preoccupation about being in control of events. He would pause before doing things due to repetitive thoughts about the need to feel "just right". This was manifested by several unusual and odd behaviour such as voluntary posturing of limbs in abnormal positions, holding a chair for a long time before releasing it, holding the side of the door before entering or exiting from a room, waiting for a long time before starting to eat, holding tiny insignificant things in between fingers, overwriting, touching walls, trees or other objects by the side while walking or even cycling and smearing spit on palms after brushing his teeth. He did not recognize these behaviours are irrational or causing anxiety. He expressed distress about losing control when he does not perform these behaviours. He also began to refuse to eat food for fear of losing control of his life. Following this, there was a gradual decline in his self-care and a significant deterioration in his academic performance.

There is no history of any psychoactive substance use in a harmful use or dependence pattern in the past.

There is no history of any first rank symptoms

There is no history of any pervasive mood symptoms in the past.

There is no history of any generalized anxiety or panic attacks.

There is no history of any other specific personality traits or primary sleep problems or sexual dysfunction in the past.

Treatment history

He was initially treated for these problems by a local psychiatrist. However, the details regarding the medications were not available. His index visit to MHC was in March 2009, when rationalization of medication was done & Fluoxetine trial(upto 60mg/day) was given. He also received treatment with Ziprasidone(upto 30mg/day) & later Paliperidone(upto 3mg/day). He showed partial response with pharmacotherapy. He has had three inpatient admissions prior to his current admission.

Family history

He is the second & last son born to his parents from a non-consanguineous union. There is no family history of any neuropsychiatric illness. His father is a businessman and his mother is a homemaker. His elder brother is a bank employee.

Developmental history

The antenatal period was supervised and uneventful. Birth was full term normal vaginal delivery with no birth asphyxia or neonatal seizure. Postnatal period was uneventful. Both motor and language developmental milestones were reported to be normal.

Educational history

He was a first year student of Bachelor's in Arts when he stopped going to college. His academic performance was reported to be average. He had good interaction with his peers and teachers until the onset of his symptoms.

Sexual development

He had male gender identity and heterosexual orientation. He was guarded about masturbatory guilt. He denied any high risk sexual behaviour.

Marital history

He was unmarried

Premorbid personality

Premorbidly he is described to be sociable, euthymic, calm and responsible person. He had good moral standards. He also had anxious and anankastic traits, e.g. preoccupation with rules, right or wrong. He used to think for a long time before taking any decision.

Physical examination

His vitals were stable and systemic examination was within normal limits.

Mental status examination

He was moderately built and well kempt and maintained good eye contact. Rapport was difficult to establish initially as he was guarded. However, with serial interviews, rapport was established gradually. He had anxious expression, but no agitation was noted. His speech was hesitant & excessively formal. His mood was anxious with restricted range and reactivity of affect. His thought process revealed circumstantiality. His content of thought revealed obsessions, mainly of orderliness & preoccupations with ideas of being in control. These obsessive thoughts were associated with compulsive acts. These obsessions & compulsions were not ego-dystonic, as he had poor insight to his problems. He was oriented to time, place & person. His immediate, recent & remote memory was intact. His attention was aroused & sustained. His intelligence was average. His personal judgement was intact but social judgement was impaired.

Provisional diagnosis

OBSESSIVE COMPULISVE DISORDER

UNDIFFERENTIATED SCHIZOPHRENIA CONTINUOUS COURSE

Aim for Psychometry

To clarify symptomatology, psychopathology and diagnosis

Tests administered

1. Sack's Sentence Completion Test

2. Thematic Apperception Test

3. Rorschach Inkblot Test

Behavioural observation

During the entire exercise, he was cooperative but required frequent prompts. He could comprehend the instructions and paid adequate attention. He appeared very anxious throughout the tests.

Rationale

Sacks Sentence Completion Test is a projective test developed by Dr.Sacks and Dr.Levy. It consists of 60 partially completed sentences to which the respondent adds endings. The respondent projects the attitudes towards a personal experience of life. It helps to elicit ideas of self perception.

Test Findings

The SCT indicates conflicts in the area of family and self and sex. There appears to be significant conflicts in his attitude towards his parents. He is closer to his mother than father. While he seems to consider them very good, he feels that his father is punitive towards him and does not

understand him well. There is significant preoccupation with perfection, control, rules and morality suggestive of anankastic traits. There appears to be fear of failure & low self-esteem and confidence. There is regret about his illness. He expressed ambivalence towards his future. There seems to be no major conflicts in interpersonal relationship. The test also reveals that he has possible conflicts in the area of sexual relationship as he remains extremely defensive about it.

Rationale

Thematic Apperception Test is a projective test used to measure the person's pattern of thought, attitudes, observational capacity and emotional responses to ambiguous test materials. It elicits information about a person's view of the world and his attitudes towards the self and others.

Test Findings

In the TAT, his stories are very detailed and vary from being descriptive to interpretative. The dominant needs identified are need for achievement, affiliation, succorance and harm avoidance. The stories reveal conflicts between achievement and abasement, aggression versus affiliation and succorance. Stories express a myriad of feelings and emotions from feelings of zest, ambition to feelings of helplessness, insecurity, guilt, anger and jealousy. Most stories reveal a press from the environment.

Rationale

Rorschach Ink Blot Test is also a projective test which provides an understanding of structure of the personality, probable psychosis if any, affectional needs and the ego strength. It also indicates degree of psychopathology.

Test findings

On the protocol he has given 28 responses indicative of average productivity with delayed mentation**.** It indicates the presence of conflicts, inner tension and excessive control. The need for affection appears to be poorly developed indicating significant lack of emotional depth which could cause problems or difficulties in adjustment to situations in life. Insensitivity to shading further indicates his poor development of need for affection. Overemphasis on form indicates neurotic constriction with a tendency to inhibit his natural responses and a lack of impulsivity. He tends to show decreased in interest in organizing his experiences and integrating it to have an organized view of the world. There is a lack of responsiveness to environmental influence. The succession of the responses are fairly rigid with elaboration of numerous responses. There is indication of colour disturbance suggesting anxiety. There is adequate number of popular responses indicating adequate ties with reality. There is persistence of theme with high emphasis on Dd and S responses. The protocol is suggestive of obsessive compulsive disorder. There are no indicators of psychosis.

Conclusion

The tests showed anankastic traits & features of obsessive compulsive disorder. There was no evidence of psychosis.

A diagnosis of Obsessive Compulsive Disorder was made.

Management

He was admitted for diagnostic clarification and appropriate treatment. He was started on Clomipramine, in view of inadequate response with SSRI. Paliperidone was tapered off as psychosis was ruled out after the tests. Non-pharmacologically, rapport was established with the patient. Cognitive Behavioral therapy – Exposure & Response Prevention was applied. His family was allowed to ventilate and was psycho educated about the nature of his illness, course, prognosis and need for long term treatment and regular follow up. He was seen to minimally improve in Occupational Therapy. At the time of discharge, he had marginal improvement in the symptoms.

CASE RECORD – 5 : Neuropsychiatric assessment

Name : Mrs. S

Age : 60 years

Sex : Female

Marital status : Widowed

Religion : Hindu

Language : Tamil

Education : Illiterate

Occupation : Housewife

Socio-economic status : Middle

Residence : Urban

Informant : Mrs. S and her son & daughter

Presenting complaints:

Difficulty in memorising & concentrating – 5 years

Suspicious belief that people are talking about her – 6 months

History of presenting illness:

Mrs. S came to our hospital with above mentioned complaints. Premorbidly, she was reported to be well adjusted individual with no deviant traits. She is a known hypertensive, on regular medications. There are no other significant medical co-morbidities. There is no significant family history for neuropsychiatric illness.

She was apparently doing well 5 years back. Since then she started complaining forgetfulness & difficulty in sustaining concentration. She would get easily distracted while doing a work. She would sometimes forget where she kept things & would search for them. Son reported that there were few instances when due to her absentmindedness & forgetfulness she prepared breakfast for him, even after he already had breakfast prepared by her just a while ago. Her poor attention, concentration & memory gradually worsened over time, but didn't affect her activities of daily living severely. She does regular household works including cooking for herself & her son. She is independent in self care.

Since last 6 months she started expressing ideas that people are talking about her. It started when she accused a lady in her neighbourhood of forcing her son to have intimate relationship with her. She reported that everyone in her locality came to know about it, and they were always talking bad things about her as she was involved in it. Her son or daughter denied any such incidents, but her belief was firm, unshakable. She made her son leave that place due to this belief. She still holds these beliefs even after changing the place. There is history of irritability & occasional mild sleep disturbance associated with this belief. Her son & daughter also reported that since last 1 month she is showing inappropriate & sexually intended behaviour towards males, including relatives like son-in-law & grandson. But she denied it.

She denied depressive ideations. She is able to perform activities of daily living independently and her biological functions were reportedly intact except occasional sleep disturbance.

There was no history of seizure, head injury, loss of consciousness, or delirium.

There was no history of any other delusions or auditory hallucinations.

There was no history of ideas or attempts of deliberate self harm.

There is no history suggestive of any first rank symptoms.

There is no history of any psychoactive substance abuse.

There is no history of any manic or hypomanic symptoms.

There is no history of any melancholic features.

There is no history of any obsessive-compulsive symptoms or panic symptoms.

There is no history of any other specific personality disorders.

Past & Treatment history:

There is no significant past history of neuro-psychiatric morbidity.

She has never been treated by a psychiatrist.

Family history

There is no family history of any neuro-psychiatric illness in his family. She has 3 daughters & 2 sons. She lives with her youngest son.

Birth and development history:

There was no information available about antenatal period. Details about birth history were not available. No information was available about birth asphyxia or any other perinatal complications. The developmental milestones were reported to be not delayed.

Educational history:

She didn't have any formal education in school. She could sign her name in Tamil.

Occupational history:

She is a housewife.

Sexual history:

She had heterosexual orientation. Her menopause was 10 years back. She denied any high risk sexual behaviour.

Marital history:

She was married to Late Mr. P who died 20 years ago in a sudden death. She has 2 sons & 3 daughters.

Premorbid personality:

She is described to be a sociable, extraverted person who was energetic in work. She didn't have any deviant personality traits.

Medical history:

She is a known case of hypertension, on regular antihypertensive medications. There is no history of Diabetes Mellitus, Hypothyroidism, Heart disease, Liver disease, Dyslipidemia. She had cataract surgery in left eye 1 year back.

Physical examination:

Her vitals were stable. Systemic examination was within normal limits. There were no focal neurological deficits.

Central nervous system:

Higher function – MMSE 18/27

Poor comprehension

Cranial nerves – No cranial nerve palsies

Motor system

Bulk - Normal bilaterally

Tone - Normal tone bilaterally

Power - Grade 5 power bilaterally

No involuntary movements

Sensory system

Crude touch, Pain, Temperature - Normal bilaterally

Light touch, Vibration and Joint position sense - Normal bilaterally

Reflexes

Superficial abdominal reflex - Present all four quadrants

Plantar reflex - Flexor bilaterally

Deep tendon reflexes - 2+ bilaterally

Cerebellar functions - No signs of cerebellar dysfunction

There were no frontal release signs

Gait – steady

Meningeal signs - Absent

Skull and spine – within normal limits

No finger anomia was noted

Right left confusion was absent

Mental status examination

She was a moderately built individual and was adequately kempt. Rapport was difficult to establish due to her poor comprehension. Her motor activities were within normal limits. Her speech was hesitant, monotonous, with slow reaction time and laconic productivity. Her comprehension was poor resulting in often irrelevant speech. Her affect was restricted, with decreased range and reactivity. She didn't have any formal thought disorder. Content of thought revealed referential delusions. She denied any depressive ideations. No perceptual abnormalities were present. She was grossly oriented to time place and person. Her recent and remote memory was intact. However, her immediate memory was impaired. In three object recall test she could correctly recall only one object. Her attention could be aroused but was difficult to sustain. Her concentration was poor. In digit subtraction test she could correctly do only one step. Historically her intelligence was average, although she was illiterate. She had grade 2 insight into her illness. Her personal & social judgement was impaired, but test judgement was intact.

Provisional diagnosis

Dementia

Organic Delusional disorder

Aims for neuropsychological testing:

1. To find out the cognitive profile of Mrs. S

2. To relate the findings to clinical presentation

Tests Administered

- Mini-mental state examination (MMSE)
- NIMHANS Neuropsychological Battery

Behavioural Observation:

She was initially cooperative for the assessment but had difficulty in sustaining her attention over the course of the assessment and hence the assessment had to be split into sessions. There was no active resistance in doing the assessment. She was not able to comprehend the instructions well, due to poor comprehension power. Her verbal communication was inadequate. There was no performance anxiety observed.

TEST RATIONALE & RESULTS

Mini-mental state examination

It was introduced by Folstein in 1975, as a screening for gross cognitive impairment. It can help to confirm diagnosis, assess the severity and, monitor the progress and outcome of treatment. MMSE measures orientation, attention and calculation, immediate and short-term recall, language, and ability to accomplish simple verbal and written instruction as well as visual construction. The total score is 27.

Test findings

The MMSE score was 18, with deficits in orientation to time, comprehension, concentration, registration, short-term recall & visual construction.

NIMHANS Neuropsychological Battery

The battery was developed by Shobini Rao et al. This tests a subject's performance across lobe functions. It has been validated to suit the Indian adult population between the ages of 16 -65. It comprises of a series of subtests that assess the following domains:

Speed (motor and mental), Attention, Executive functions, Comprehension, Learning and Memory, Visuo-spatial construction & Learning and Memory).

Motor speed:

On the finger tapping test her average numbers of tap was 43 in right hand & 40 in left hand which was above 50^{th} percentile.

Mental speed:

On the digit symbol substitution test, the total time taken to complete was 682seconds which is below the 5^{th} percentile, indicative of significant impairment in mental speed. She made multiple mistakes in this test.

Sustained attention

On the digit vigilance test, the total time taken to complete was 1095seconds which is below the 5th percentile. The total errors are 60, which is below 4th percentile, indicative of significant impairment in sustained attention.

Focussed Attention

On the Colour Trails Test 1, the total time taken to complete was 231seconds which is below the 2nd percentile and the total time taken to complete Colour Trails Test 2 was 414seconds which is also below the 10th percentile. She also made 3 errors while doing the latter one. Both indicative of significant impairment in focussed attention

Executive functions

- **Phonemic fluency**

  Phonemic fluency was assessed by the Controlled Oral Word Association Test (COWAT). On the COWAT, the average new words generated were 2, which is between 15th to 30th percentile and is indicative of impairment in phonemic fluency.

- **Categorical fluency**

  It was assessed by the Animal Names Test. The average new words generated were 4, which is below the 15th percentile, indicative of impairment in categorical fluency.

- **Design fluency**

  In design fluency test she could draw 2 designs in free condition and 1 design in fixed condition, both of which are below the 5th percentile, indicative of impairment in design fluency.

- **Planning**

  Planning was assessed by the Tower of London Test. The total number of problems solved in the minimum number of moves is 6, which is at the 40th percentile. The mean time taken, the mean moves and the number of problems solved with minimal moves are as follows,

No of moves	Time taken	Percentile	Mean moves	Percentile	No of prob with minimal moves
2 moves	9.5s	56th	2.5	<100th	1
3 moves	43s	<4th	4.5	<30th	2
4 moves	154s	<4th	16.5	<4th	2
5 moves	45s	<15th	8.5	<44th	1

The scores suggest mild impairment in problem solving ability. There is fluctuation in the score which could be due to poor attention & comprehension, as the patient was making similar errors.

Working memory

Working memory was tested by verbal working memory N Back test. There were 11 errors in 1back test, which is below 6^{th} percentile, and 9 errors in 2 back test, which is below 21^{st} percentile. This result is indicative of significant impairment in working memory.

Logical memory

On passage recall test, she couldn't recall any facts in immediate or delayed recall, even after giving prompt. This indicates severe impairment in logical memory.

Impression

The Test findings suggest impairment in most domains of neuropsychological functioning including attention, mental speed, executive functions, working memory and logical memory. This is suggestive of a global impairment of functioning suggestive of deficits in frontal, temporal & parietal regions. The profile of deficits – significant deficits in comprehension, attention, memory & executive functions, with relatively intact motor speed – is suggestive of Dementia in Alzheimer's disease with early onset.

Management

Mrs. S and her family were educated on the nature of illness and, about the assessment results. She was treated on out-patient basis. Blood investigations were done which were within normal limits. She was started on Quetiapine trial for her delusional disorder. Liaison was done with the concerned departments for the rationalization of her medications. Strategies to deal with the behavioural problems associated with dementia were discussed with the family members. Reviews and further assessments as per need were scheduled.